



Member Information

This membership category is for MDs and DOs currently licensed and practicing outside the domestic United States and its territories. Please print clearly. This information will be used on the Online Provider Directory.

First, Mid and Last Name: _____

Designation (MD, DO, FACPh etc.): _____

Company: _____

Street Address: _____ Suite: _____

City: _____ State/Province: _____ Zip: _____ Country: _____

Personal Email (Required. This will be used as your Member Login): _____

Website: _____ Twitter: _____

Phone: _____ Fax: _____ Cell Phone: _____

Demographic Information

Current Specialty: Primary: _____ Secondary: _____

Medical School: _____ Grad Year: _____ License #: _____

Residency Specialty: _____ Year you started phlebology: _____

Birth Date: _____ AMA #: _____ Gender: Male Female

I was referred to the ACP by:

Colleague: _____ Education Meeting: _____ Other: _____

Other Medical Society Affiliations (AVF, SIR, ACS, etc.) _____

Payment Information

Annual Dues for ACP Membership	=	\$250.00	USD	
One-time Only Application Fee	=	+\$ 95.00	USD	
Coupons, Discounts, Certificates	=	-\$ _____		Coupon code: _____
Final Total Due	=	\$ _____		

For Office Use Only Received:	Entered in DB/ID #	Make File Folder	Payment Processed	Email Confirm	Packet Sent
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Member Physician Payment Information

Check Made Payable to AMERICAN COLLEGE OF PHLEBOLOGY Amount: _____

Credit Card: MasterCard Visa American Express Discover Expiration Date: _____

Credit Card Number: _____ Security Code: _____

Name on Card: _____

Billing address if different from above:

Street Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Please mail, fax or email this form to the ACP offices below. You may also fill out and submit your application online at www.phlebology.org/membership